STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 255296	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DESOTO HEALTHCARE CENTER	**7805 SOUTHCREST PARKWAY , SOUTHAVEN, Mississippi, 38671**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS The State Agency (SA) conducted an annual recertification survey and Complaint Investigation (CI), MS #3193815, at the facility from 9/28/2026 through 9/30/2026. CI MS #3193815 was investigated for Quality of Care, and no deficiencies were cited related to this investigation. During the survey, the SA determined the facility was not in compliance with the requirements of participation in Medicare and Medicaid and cited F641. The facility had a census of 94 and was licensed for 120 beds.	F0000		11/06/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each	F0641	F 641 Accuracy of Assessments Residents # 3, identified as having inaccurate assessment documentation, were reviewed by the Interdisciplinary Team (IDT) on 9/29/26. The Minimum Data Set (MDS) was audited and corrected to accurately reflect the resident's clinical status and supporting documentation in the medical record on 9/29/26 by MDS Nurse. The facility has determined that all residents receiving medications have the potential to be affected. The Staff Educator completed an in-service on 9/29/26 with the MDS nurses on the MDS policy. The Quality Assurance Nurse will perform weekly audits of five MDS assessments beginning on 10/5/26 for four weeks, then monthly audits for three months to ensure compliance with accuracy and supporting documentation requirements. The Quality Assurance Nurse will report any identified issues to the Director of Nursing, who will present all findings to the Quality Assurance Committee on 11/5/26 for review and recommendations. The Director of Nursing will continue to bring findings from the audits to the Quality Assurance Committee monthly for three months to ensure compliance is	11/06/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F0641 SS = D	Continued from page 1 assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded when the MDS was incorrectly coded for the presence of pain when documentation during the look-back period did not support presence of pain for one (1) of 19 sampled residents. Resident #3 Findings Include: Record review of facility policy titled “MDS Assessments” revised 3/11/2026, revealed, “The purpose of this policy is to ensure that all residents receive an accurate assessment, reflective of the residents’ status at the time of the assessment, by staff qualified to assess relevant care areas...” Record review of MDS with an Assessment Reference Date (ARD) of 9/3/2026 revealed under "Section J", pain presence was coded “1. Yes.” Record review of Resident #3’s Medication Administration Record (MAR) for August 2026 and September 2026 revealed Hydrocodone-Acetaminophen 5-325 milligrams (mg) every six (6) hours as needed for pain ordered on 9/5/2025. The medication was not administered during the five (5) day look-back period of 8/30/2026 through 9/3/2026. The MAR further revealed that pain monitoring was ordered every shift and a documented pain of “0” was documented each day during the look-back period. During an interview on 9/29/2026 at 3:45 PM, the MDS Coordinator confirmed that Resident #3’s MDS, with an ARD of 9/3/2026, was incorrectly coded in "Section J" for pain presence. She stated, “It was just an error.” She confirmed that Section J0300 should have been coded “0. No.” She further confirmed there was no documentation on the MAR to support the presence of pain. The MDS Coordinator acknowledged that the MDS assessments should be coded accurately.	F0641	Continued from page 1 maintained. The facility will achieve compliance by 11/6/26.	11/06/2026

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F0641 SS = D	Continued from page 2 During an interview on 9/29/2026 at 4:00 PM, the Administrator acknowledged that Resident #3's MDS, with an ARD of 9/3/2026, was incorrectly coded in "Section J" for pain presence. He confirmed that the MDS should accurately reflect the resident's status and acknowledged that MDS assessments should be coded correctly. Record review of "Admission Record" revealed Resident #3 was admitted to facility on 9/5/2025 with a diagnosis of Unspecified Intracapsular Fracture of Right Femur, Subsequent Encounter for Closed Fracture with Routine Healing. Record review of MDS with an ARD of 9/3/2026 revealed under Section C, a Brief Interview for Mental Status (BIMS) summary score of 2 indicating Resident #3 was severely cognitively impaired.	F0641		11/06/2026